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THE HOSPITAL BULLETIN

OF THE UNIVERSITY OF MARYLAND

BALTIMORE MEDICAL COLLEGE NEWS

VOL. IX AUGUST 15, 1913 No. 6

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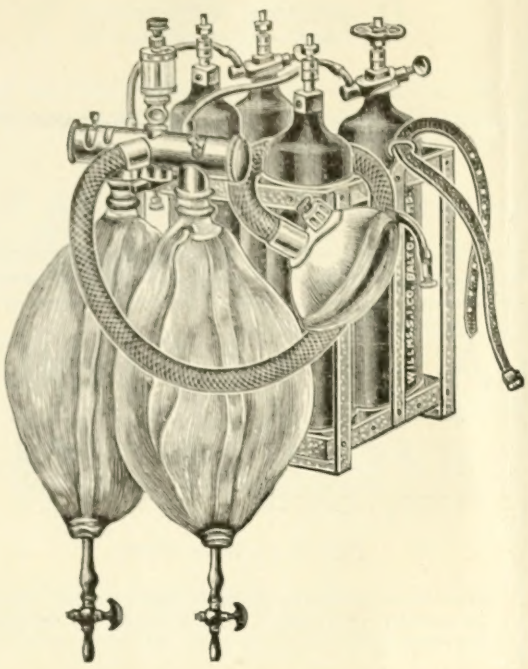

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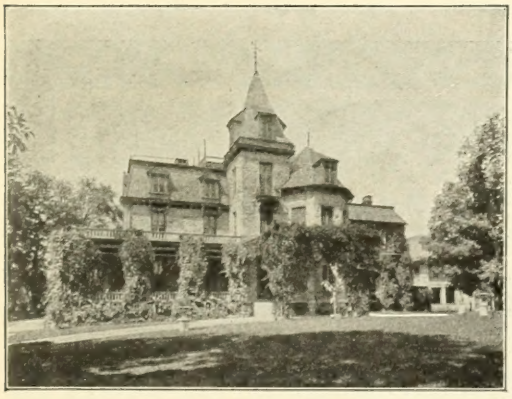

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RADICAL AND CONSERVATIVE MANAGEMENT OF SOME OBSTETRIC PROBLEMS IN GENERAL PRACTICE.*

By Roscoe D. McMillan, M.D. (1910).
Red Springs, N. C.

It is not my purpose in this article to take up in a categorical manner the various obstetrical problems encountered by the general practitioner, but merely to select from this broad field a few of the questions involving doubt and uncertainty which so often confront us.

First, in regard to the country midwife. So much has been said upon this great evil, and absolutely nothing done by our profession toward its elimination, that only a few words will suffice to pass it over. Our last General Assembly provided us with the vital statistics law. This, in my opinion, will lessen to a great extent the midwife problem, as these statistics will show the number of cases delivered by midwives and by physicians; the number of deaths of mothers and of children, the appalling effects of ophthalmia neonatorum, or what not. This, I think, will be the greatest help toward educating the public as regards elimination of the country midwife, the greatest menace to the general public in our State today.

The demands made on the general practitioner in this branch of medicine make it one of the most tedious, painstaking and difficult branches of our profession, not only in this light, but sociologically as well. I mean we, as physicians and guardians of public health, can do much to lay the foundation for much encouragement along this line. Preventive medicine is one of the highest aims for which we are striving in this scientific age. It is a well-known fact that we all live too lavishly, eat and drink to excess. This brings us to another problem, that of early and late marriage. Encourage early marriage by all possible means. We all know a woman has a much easier time if she bears her first child before she is 26 years of age. After this age the dangers to mother and child are, as a rule, greater. In this country the marriage age is too high. The young man spends his money lavishly on high living and puts off marriage, time passes on, he contracts a case of gonorrhea, thinks he is cured, marries, innocently transmits it to his wife, and she lives a life of misery the remainder of her days. Encourage early marriages, and require a medical certificate from the man before he is allowed to marry any woman. If some of these things were gone into more deeply, the great problem of radical and conservative obstetrics would not be so large a field as it is.

While it may be true that the management of normal labor demands but little knowledge of obstetrics, and that childbirth, under most circumstances, will terminate favorably, it is nevertheless true that nothing but a thorough knowledge of obstetrics will qualify a physician to meet the difficulties that arise from time to time in the practice of this branch of medicine. Progress in this specialty has advanced in the last few years to such an extent that no condition arising from pregnancy, labor or parturition is without a remedy. I do not say that the proper thing is always done, or that any of us are so skilled as never to fail. We have all met conditions that were trying in the extreme, and have found it necessary to do the best we could under unfavorable circumstances. Often we have looked back on some of these cases with considerable regret.

Emergencies, such as hemorrhage, serious symptoms of toxemia, eclampsia, dystocia and others are often encountered under circumstances giving no opportunity to do aseptic surgical work,

*Read before the Medical Society of the State of North Carolina at Morehead City, N. C., June 18, 1913.

as compared with a well-equipped operating-room, with trained assistants. In all obstetrical procedures asepsis is the ideal method to be followed in the management of any case, not only asepsis, but antisepsis as well, for we are dealing with a field immediately proximal to the birth canal that cannot be sterilized and cannot be kept clean at all times.

Of great importanec to the present, as well as future welfare, of the patient is a correct diagnosis of the presentation and position of the foetus and the relation of its size as compared with the mother's pelvis. Obstetrical diagnosis is of far greater importance and far more worthy of serious consideration than is given to it by most physicians in general practice. If more attention were given this, the damage to infants and mothers would be greatly lessened. Also such complications as dystocia, malpresentation, malposition, placenta praevia, symptoms of toxemia, etc., would be recognized early enough to permit removal to a well-conducted hospital, not as a last resort, but in ample time. This can only be done by careful observation of our patients and making correct and early diagnosis.

I venture to say that the majority of physicians in general practice do not like obstetrics; the remuneration is comparatively small for the patience and skill required. As a result, a great many physicians take obstetrical cases with the sole object of retaining the family practice. They do not appreciate the responsibility; they do not study their cases enough to have any apprehension of trouble. They go on and on until some unthought-of complication suddenly arises that demands presence of mind and skill far beyond that possessed by the average general practitioner.

To what extent shall we be radical, and to what extent shall we be conservative in the application of forceps? This sometimes taxes the skill of the physician to the utmost. It is not easy to select the right time to interfere, knowing so well that Mother Nature is the best doctor we have. It has been said that we should wait to see what the woman is able to accomplish, not what she is able to endure. If we wait until the signs of danger to the mother or child are present, very often the damage has already been done. It is a shame to let a woman suffer many hours in the second stage, waiting for the danger signs to appear. I have made it a rule when the head has descended well on the perineum and makes no progress for two and one-half hours to apply forceps. Watch carefully the occipto-posterior presentations. Leave them to nature as long as possible. When you are sure rotation of the head is arrested, prompt delivery by forceps is indicated, remembering when the head is arrested at the superior strait, version and extraction should be resorted to.

Next comes the large number of complications which affect the mother, and secondarily the child. Eclampsia, pneumonia during labor, infection during labor, tuberculosis, edema of the lungs, placenta praevia, prolapse of the cord, all are clear-cut indications for forceps.

Scientific obstetricians, even if they allow theoretical teachings to influence them in their other cases, will admit that safety to mother should take precedence over safety to child when it is possible to save but one, and that only at the expense of the other.

Deficient Uterine Contractions.—While I admit this does occur occasionally, it is not so serious. The contractions may weaken at times, indeed, may cease entirely, only to rest awhile and return with renewed activity if given time; only rarely does it give sufficient trouble to justify forceps.

Every case of contracted pelvis is a law unto itself, demanding its own particular consideration. Someone has said: "Forceps fit the contracted pelvis like the fist on one's eye."

A marked contraction of the pelvis has but one indication, Caesarian section. The lesser and more moderate degrees puzzle the obstetrician greatly, and not all agree as to the best course to pursue. Occasionally success follows the use of forceps and a living child is dragged through a cramped pelvis. This, however, is bad obstetrics, even if the child lives; it is usually the recipient of some permanent injury, and perhaps dies in a few days.

Lastly, I beg you watch your obstetrical cases more carefully, if you see and recognize these cases of pelvic contraction or complications, whatever they may be, early enough that something may be done to save many valuable lives that go to their death annually on account of careless obstetricians.

THE PREVENTION OF TUBERCULOSIS IN SCHOOL CHILDREN.

By Dr. Ernest Seth Bullock (Class of 1911).
Wilmington, N. C.

That tuberculosis should be prevented needs no stronger argument than that it is the most frequent of all diseases, causing the death of one in every eight persons. Our country pays a tax of $200,000,000,000 yearly because of the ravage of this scourge, and in the same length of time as many people die of it as were killed on both sides during the four years of our Civil War. The fact that almost every person is at some time in their life infected with this disease is evidenced by the results of 1300 autopsies held on subjects over 40 years of age which showed the presence of tuberculosis, either healed or active, in 97 per cent. of them.

If the disease is hereditary, as was previously thought, its prevention would be well-nigh impossible. On the contrary, its presence in the human race depends upon the introduction of the specific germ into the body from an outside source. This occurs by means of food and in various other ways. Those coming most directly under the control of the teacher are air infection, the variety which is by far most frequent.

The most potent way of polluting the air is by spitting and through the droplets that are constantly thrown from the mouth while talking, sneezing and coughing. To illustrate this, talk before a mirror and notice the innumerable droplets which accumulate. When closer than four feet these droplets are constantly interchanged and inhaled by those who stand this near.

A moderately advanced consumptive throws off daily in the sputum about 150,000,000,000 organisms, and the control of these is the teacher's problem; for every schoolroom of moderate size must contain more than one tubercular pupil. So long as the sputum is wet these organisms are held captive by the fluids, but when it dries the germs are hurled into the air by drafts and are then inhaled, finding lodgment on the fertile disease beds that line the throat and lungs. By the time the sputum has dried most of the organisms have died, but a host remains active. In cool dark places the organisms may live for months, but as a rule they lose, after 8 or 10 days, the power of infecting through the usual channels. If the spread of the disease was not held in check by some such means, with our present effort we could not hope to perpetuate the human family more than one generation. As a further aid to human protection it is gratifying to know that the tubercular germ does not multiply while living without the body.

Every child must expectorate at some time, and many children do so very often during the months when colds are most prevalent. To these children the schoolroom offers three alternatives: one to swallow the sputum as it is raised; if a child is tuberculosus this leads to infection of the digestive tract, imposing great injustice upon the child, who is ignorant of this danger. Another child, instead of swallowing the sputum, would expectorate on the floor or in a corner—a practice exceedingly common among many school children. A third child will expectorate in his handkerchief, which is then returned to a dark pocket and soon becomes dry. To use the handkerchief again, it is drawn from the pocket, flourished through the air en route to the face, showering the tubercular organisms into the air, which must be breathed by those nearby.

The sputum source of danger can be best controlled by the use of cuspidors. A more efficacious, but a less practical, way is by the use of the individual sputum cups with which all are familiar. The cuspidors should contain a 5 per cent. solution of carbolic acid—or better still, a solution of lysol, which dissolves the mucus and more readily attacks the bacilli. These solutions require about 24 hours to kill the organisms. By the time the cuspidors are to be emptied the germs are of little danger. Further, the fluid prevents the drying of the sputum and pollution of the air. The number of cuspidors should be sufficient to allow their use without permission, the child being allowed to walk a few steps to expectorate. Some of the more virile organisms will escape these precautions. A moderately large number of germs is necessary to cause an infection, so if the child's health is sufficiently good, the lungs are able to resist the attack of the undestroyed organisms.

A child spends about one-fifth of its daily life in your schoolroom; therefore, this should be conducted with a view to health and comfort. The room should have the largest possible number of windows consistent with its dimensions. They should begin about four feet from the

floor, extending as high as possible toward the ceiling. The total area of the windows should be equal to at least one-eighth of the floor space; for each person an allowance of 250 cubic feet of air space should be made. If the window area and the allotted air space for each pupil is less than it should be and its control beyond your power, the difficulty must be overcome by proper ventilation. If the windows are so arranged that their opening will make those near by uncomfortable, this may be prevented by the use of stove pipe ventilators. They are cheap and direct the incoming air in the proper direction, that is upward, where the expired air finds its way outward through the lowered sash. If the entrance for the air is larger than the exit, the draft will be lessened. If each window is provided with two shades, it will allow the entrance of light and exclusion of the sun from the scholar's book.

During recess the windows should be opened. Twice a day at proper intervals, the windows should be raised; the children standing by their desks should go through some simple exercise with the arms and legs. The time required from the opening to the closing of windows is less than five minutes. Aside from doing much for the health it arouses the pupil and favors attention. Following the exercises the chill of the room is not felt and it quickly regains its heat. A temperature of about 70 degrees is conducive to the best work, if warmer than this the children become languid and the clothes that make them comfortable outside now cause them to perspire.

A vessel of water should always be near the source of heat; this will afford moisture for more comfortable breathing. The walls of the room should be white and this coating renewed at least once a year. The chalk dust should be wiped away daily with damp cloths. The floors should be wiped and re-oiled once a week.

Some of you may think these suggestions are impractical for your school, but should you make continuous effort in this direction you would be surprised at your success. For instance, you might obtain permission and with the help of your school children cut down the trees that obstruct the sunlight; for few things are so destructive to the cause of tuberculosis as the direct rays of the sun.

That faulty positions may not be assumed, the children should be seated according to size, not scholarship. The desks should be one inch higher than the elbows—the seat at least eight inches wide and built at such a height that when the legs are at right angles the feet will rest firmly on the floor. It is not wise for children to enter school before the age of seven, and for the first few years their instruction should be confined to the classroom. During these early years the period of confinement should be about three hours; later, this period may with impunity be extended to six hours. Only a small amount of work should be assigned to be done at home, for the present method of making pupils do most of their work out of school is detrimental to health.

If the following "health rules" were printed and tacked upon the wall they could be copied and learned. These could be better understood if you would explain just why each precaution should be taken. As an expression of strength and manliness many boys expand their chests and allow others to strike them with full force, the frequency with which such blows are followed by tuberculosis makes one shudder. These boys are ignorant of this danger, but you know it and should tell them of it.

HEALTH RULES.

1. Health is wealth.
2. Do not put pins in your mouth.
3. Do not hold money in your mouth.
4. Do not put your hands in your mouth.
5. Do not put pencils in your mouth or wet them with your lips.
6. Do not wet your finger in your mouth when turning the leaves of books.
7. Do not put anything into your mouth except food and drink.
8. Do not spit on your slate or on the floor or sidewalk.
9. Do not pick your nose or wipe it with your hand or sleeve.
10. Keep your face, hands and finger nails clean.
11. Keep the interior of your body clean by allowing nothing to go into it excepting food and pure drink.
12. Do not keep your rubbers on in the schoolroom.
13. Do not sit with wet feet or damp clothing; resort to the stove or register until they are dry.

14. Do not swap parts of apples, candy, chewing gum, half-eaten food, whistles or anything that is to be put in the mouth.

15. Never cough or sneeze in a person's face. Turn your face to the side and hold a handkerchief before your mouth.

16. When drinking rinse out the cup, and empty what water you leave into a wash basin or sink.

17. Breathe only fresh air day and night; simply avoid draughts.

18. Breathe, sit, stand and walk correctly. In so doing you will do more to prevent consumption than all the physicians combined. A good pair of lungs is the most efficacious barrier to this disease.

19. Go to bed early, rise early and take a moderate amount of physical culture.

20. Study the physiology—to know how to use rightly and take proper care of every part of the body.

The probability of tubercular infection is greatly increased by certain diseases, notably pneumonia, influenza, diphtheria, scarlet fever and measles; the last-named is very important, for during its course and some time after, all resistance to tuberculosis is lost. Long-standing colds should always be looked upon with suspicion and followed by appropriate suggestions.

During your visits discuss clothes with the mother. Flannels are best worn next to the skin; they absorb moisture, hold heat and absorb less odor than other materials. Bear in mind that too much clothing may be as harmful as too little. During these talks, find how much assistance the parents give in the work of their children, and if too much or too little, tell them of it.

If the child be over active and uses the afternoons for the preparation of his lessons that his nights may be spent in pleasure or reading, the parents should be shown that after remaining at school for the best part of the day mental relaxation is needed and the child should be encouraged to spend his afternoons in play. At night, with rested mind, the lesson will come easier; reading in a properly lighted room is without harmful effect upon the eyes.

Of the suggestions that have been offered, none are beyond the means of the poorest school district, and these conditions may be obtained by every teacher who has the interest and the energy to work for them. The application of these suggestions, together with those that occur to you, will, with sincere work assisted by the school committee and parents, bring you to the early realization of all your hopes; nor will your efforts pass unnoticed, for you will be a teacher such as the world is looking for and will pay well.

FROM CHESAPEAKE BAY TO PUGET SOUND AND BACK.

By Randolph Winslow, M.D.

1. To Minneapolis and Glacier National Park.

The American Medical Association met in Minneapolis, from June 17 to 20, this year. Leaving Baltimore on Saturday evening you reach Minneapolis about 8 o'clock Monday morning, and you have the choice of several different routes for the journey. The meetings of the Association were held in the buildings of the University of Minnesota, which were admirably adapted to the purpose, but were a rather long distance from the hotels. In order to overcome this handicap luncheon was served daily (free of cost) to the members and their guests on the campus and in the buildings of the University. Over 3200 members registered as in attendance, which was a large number when we consider the somewhat remote and isolated location of the place of meeting. The social diversions were numerous and enjoyable, and every effort was made to render the sojourn of the visitors memorable. The cities of St. Paul and Minneapolis are practically continuous and are known as the Twin Cities. St. Paul is the State capital and is a fine city, but has not as large a population as Minneapolis, nor is it as active a business center. Minneapolis is a beautiful city, situated on both sides of the Mississippi River, at the head of navigation. Within the city limits are several beautiful lakes, and nearby are other large and picturesque lakes. Lake Minnetonka is only a short trolley ride from the city, and offers an attractive waterside resort right at their doors. The population of the two cities exceeds a half million and is rapidly increasing. The University of Minnesota is located at Minneapolis, and is said to be the richest seat of learning in the world. It has a magnificent campus, which is being developed on artistic lines, and many and beautiful buildings. About 6000 students are in attendance. It was a

pleasure to meet several graduates of the University of Maryland in this far-off country, who have succeeded in gaining substantial recognition in their professional work. Dr. F. W. Schlutz and Dr. W. R. Humphrey, both of the class of 1902, are successful practitioners in their respective communities. After an enjoyable sojourn of five days in Minneapolis the writer entrained at 11.20 P. M. on June 20, on the Great Northern Railroad, for Glacier National Park. Two nights and a day bring you to Glacier Park Station. The country traversed after crossing Minnesota is not attractive. First we journey through the well-cultivated, rolling, but almost treeless prairies of North Dakota, with small farmhouses and huge barns, and then across the barren plateau of Eastern Montana, in which cultivated areas are few and far between, but where large droves of horses and cattle are pastured. As we approach Glacier Park we come into the reservation of the Blackfeet Indians and have many opportunities of seeing Mr. and Mrs. Lo in their own land. The Indians, however, are nearly all pretty well civilized, and usually wear the white man's clothing; in fact, many of the squaws dress handsomely. Glacier National Park is situated in the northwest corner of Montana and is about 1500 square miles in extent. While it has been resorted to by hunters and fishermen for some time, it has only been opened as a national park since 1910. It is the property of the United States and is maintained as one of the national playgrounds for the benefit of all the people. It is an excedingly rugged area, with lofty mountains, swift streams, beautiful lakes and numerous glaciers. There are 250 lakes, of varying sizes, and 80 glaciers. Tourists from the East disembark at Glacier Park Station, where there is a beautiful and modern hotel constructed of logs. Here one must outfit for the trip through the park, as all his baggage must be carried in a knapsack or in a pouch that can be swung from a saddle. While the days are comparatively warm, the nights are cool and heavy clothing is required, and either overcoats or sweaters are usually worn. From Glacier Park Station a good automobile road, 32 miles in length, has been constructed to St. Mary's Camp, which is a collection of Swiss chalets, where rude but comfortable accommodations are found. We are here in the wilds, and the roughest clothing is worn. St. Mary's Camp is one of many that the Great Northern Railroad has built for the entertainment of visitors. Swiss chalets, with usually one room, a huge fireplace, in which a blazing fire of logs is lighted at night, and four cots with heavy blankets, constitute the lodging quarters of the tourist. He washes his face in a tin basin, and the other accessories of civilized life are of the rudest character. His meals are partaken of in another rough building, and, though ample in amount, are plain in character. At most of the camps, however, fresh fish are served right out of the lakes and streams. The season was late this year and the most attractive trails and passes were covered with snow, so that it was not safe to attempt to cross them. This was especially the case with Gunsight Pass, which is the continental divide between the Atlantic and Pacific coasts. St. Mary's Camp is situated on the hillside overlooking one end of Upper St. Mary's Lake, and from here gasoline

UPPER ST. MARY'S LAKE, GLACIER PARK.

launches run regularly up and down the lake, a distance of about 10 miles. The ride from St. Mary's Camp to Going-to-the-Sun Camp is very beautiful. Lofty mountains surround the lake and come down to the water's edge, and there is usually a stiff breeze blowing and the spray dashes over the boat, requiring rubber coats or "slickers" for protection. Near the upper end of the lake, at the narrows, Louis W. Hill, son of James J. Hill, has erected a handsome summer home of the chalet type, and here also is the permanent camp, known as Going-to-the-Sun Camp, from its proximity to the mountain of the same name, which is one of the loftiest peaks in the park. To my mind this is the most attractive part of the whole reservation; the pretty chalets, [illegible] are common in the neighborhood of this glacier.

CROSSING SWIFT CURRENT CREEK.

situated on the hill overlooking the water; the sapphire-blue lake, surrounded by green-clad and often snow-capped mountains, combine to form a charming vista. Boating and fishing may be enjoyed, or one may take walks or rides over the mountain trails. I remained here over night, and in the morning, after an ample meal, took the launch back to St. Mary's. A young man was running the boat, who afterward addressed me by name, and said he knew me, as he had been employed by Dr. Compton Riely in Baltimore. From St. Mary's Camp to Many Glacier Camp is 24 miles by stage, over a rough road, and about 20 miles on horseback, over a still rougher trail. The party I was with wanted to take the trail, and I had to do likewise. A rough mountain pony and an elderly man, who has not ridden for some 30 years, do not make agreeable companions, and the most delightful time of the ride was when I dismounted at the end of the journey. The trail led through swift and icy-cold streams, which the horses could scarcely buffet, and over steep and thickly wooded slopes, where one was in danger of being swept from his horse by the branches or of slipping off backward. In fact, some of the party did have rather severe falls. Notwithstanding the difficulties and ills mentioned, the ride was a beautiful one and well worth the discomforts entailed. As we approached our goal the Grinnell glacier came into view. This enormous mass of ice is six miles in length and one mile in width, and is the source of the cold and swift streams previously alluded to. The air becomes chilly and clouds and fogs

Many Glacier Camp is situated near this glacier, on Lake McDermott, another considerable body of water betwen contiguous mountains. There is an extensive flora in this region, and the hillsides and dales are carpeted with brilliant-colored flowers.

Wild animals also abound in the park, as bears, deer, Rocky Mountain goats and big-horn sheep, but they do not molest human beings, and in turn they are not hunted. There are no permanent inhabitants in the park, since the Government has removed all squatters and Indians to other locations. We spent a night at this camp. The rain came down in torrents, but with roaring fires and merry jests the time was passed pleasantly until our tired bodies demanded rest. The next day we retraced our steps on horseback, but followed the road, a distance of 24 miles. In the middle of the day we stopped at the house of a

white man who was married to an Indian woman, and who had several very good looking sons and a daughter. Here we sat down to an excellent lunch, prepared by the Indian wife, and well served by herself and daughter. This family formerly lived in the park, but had been dispossessed, and were now located in the Indian reservation, just outside of the park. They had a very nice home, with carpets and good furniture, graphophone, sewing machine and many of the comforts and conveniences of life. The white man thought he had been badly treated by the Government and had entered suit for damages.

Reaching St. Mary's Camp, we took automobiles for Glacier Park Hotel, where we arrived about 6 o'clock in the evening, in time for a first-class dinner. After dinner we took the train for Belton, the western entrance to the park, 58 miles distant. Here is a good chalet settlement, besides other houses and stores, and we were well accommodated in a chalet with separate rooms and a bathroom. The next morning we took stage from Belton to Lake McDonald, a distance of 3 miles, over a good road and through thick forests. Reaching the lake, a launch was in readiness to convey us to Lewis' Camp, near the upper end of the lake. This is probably the largest lake in the park and is a beautiful sheet of water, well stocked with gamey fish. Lewis' Camp is called Glacier Hotel, and consists of many small cabins, with electric lights, a large dining pavilion and a hall for dancing. The electricity is generated by a mountain stream. This is a very comfortable as well as pleasant place at which to spend a vacation. The fishing is excellent, and boating, riding or walking to the nearby places of interest afford sufficient diversion. All of the camps in the park belong to the Great Northern Railroad except those on Lake McDonald, which were in existence before this area became a national reservation, and were well patronized even then. Mr. Lewis owns a considerable place here and is said to be a rich man. He is a collector of furs and skins, and in winter goes to Alaska to purchase these peltries. He has a large collection of skins, mounted animals, bones of the mastodon and other objects of interest. The return trip down the lake was pleasant, and the coach ride to Belton terminated our journeyings in the park. Another comfortable night was spent in our chalet, with a huge fire of crackling logs and good, soft beds with a-plenty of blankets on them, and the next morning, June 26, we again started toward the Pacific Coast and the sunset.

MOUNT MERRITT, GLACIER PARK.

I have been asked how Glacier Park compares with the Yellowstone. They cannot be compared. Glacier Park is a wilderness, rough and wild, of snow-topped mountains, beautiful colored lakes, most of them small; glaciers and cascades; the mountains and hills covered with fir, spruce, pine, cedar and birch trees in profusion. It is austere and somber, but beautiful and exhilarating. The Yellowstone Park is a museum of natural curiosities—wonderful, diverse and also entrancing. One cannot fail to realize that that earth's crust is very thin in the Yellowstone and that subterranean fires must be very near the surface, and to wonder if the whole area will not blow up some time. The Yosemite Valley Park is more like the Glacier, but is small in comparison and is much more parklike in appearance. One needs to see them all, as well as that gigantic

chasm, the Grand Canyon of the Colorado. They are all wonderful and sublime, but different, and each has its own individuality.

(To be continued.)

FAT EMBOLISM.

By William S. Walsh,
Junior Medical Student.

Of all forms of embolism that of fat is most common, but its importance relative to its frequency does not correspond, since, in the majority of instances, no symptoms are produced, and it is only in those rarer cases where the fat globules lodge in the lungs, brain or kidneys that the typical symptoms of fat embolism become manifest. It is of greater surgical than medical interest, for the severer forms are practically always the result of traumatism. It occurs only when the lesion is situated in tissues containing an abundance of fat (such as the medulla of bones, the subcutaneous tissues, etc.), when a vessel wall has been injured and when there is sufficient force to propel the fat into the open vessel.

From the literature on the subject the conditions which may give rise to fat embolism are many and varied. Thus, it has occurred after injury to the panniculus adiposus attending severe contusions, from hemorrhages into or rupture of the liver, as a result of acute inflammatory diseases of bones, from the forcible straightening of anchylosed joints, and from injury to the pelvic fat during childbirth. It has occurred after amputation of a carcinomatous breast in a fat woman, and has been demonstrated as having resulted from fatty metamorphosis of thrombi composed of endothelial cells and atheromatous blood plates. Yet the importance of the above conditions as causative factors of fat embolism is, all in all, minimal for the condition most favorable, and most frequently its cause is injury to the long bones. It very rarely, if ever, occurs in children, for the reason that the medulla of their bones contain but little fat.

Pathology.—The fat corpuscles first lodge in the capillaries of the lungs, and if present in only small quantities no serious disturbances may ensue, provided the heart action be strong and the patient be not debilitated by pre-existing disease. These globules are disseminated throughout the body in the circulation. When present in larger quantities, however, they may give rise to grave symptoms described below under the symptoms of lung, fat embolism. Post-mortem examination of the lungs in fatal cases reveals the capilliaries plugged by many fat emboli, pulmonary infarcts, hyperemia and edema. The alveoli are swollen and filled with erythrocytes, with fibrin and with large and small colorless corpuscles. If the patient survives the pulmonary complication, and the heart action remains strong, the embolic masses will be propelled into the general circulation to lodge in the various organs, particularly the spleen, liver, kidney, brain and cord.

In fat embolism experimentally produced in animals the following lesions have been noted:

Kidney—Glomeruli plugged by groups of fat cells; beneath the capsule many ecchymotic areas.

Liver—Passive congestion marked; fat cells within the acini and at their periphery.

Brain—Veins of the pia filled with dark blood; arteries empty or nearly so; hemorrhagic foci on cross-section; red blood cells in the perivascular spaces; emboli most abundant in the vessels of the pia and the retina.

Providing the case does not terminate fatally, the oil globules are disposed of by oxidation and saponification by the plasma, by the phagocytes, by the liver and by the kidney.

Symptoms.—The interval of time elapsing between the time of accident and the appearance of the first symptoms varies from a few hours to a number of days. The symptoms vary according to the organ or organs which are involved. The lung is most frequently the site of the emboli, and the symptoms are consequently those of pulmonary embarrassment, viz., rapid respiration, dyspnea and pallor, followed by cyanosis and failure of the circulation; the expectoration of bloody, frothy mucus, with the physical signs of pulmonary edema. The temperature may be subnormal, normal or elevated; the pulse is rapid; the pupils contracted. Many coarse râles are heard in the chest, but percussion gives a clear note. If these symptoms develop a few hours after the accident, they may be masked somewhat if the patient is also the subject of shock. Due to the emboli, pulmonary edema develops, which, as it increases still further, embarrasses the heart action.

Next to the thoracic complications, in the view-

point of frequency, are those of the cerebrum. The cerebral symptoms are due to a diffuse involvement rather than a localized embolus, and consist usually of delirium, somnolence, coma, hemorrhages and thrombosis. Localized paralysis, vomiting and general convulsions have been noted. In rare cases ecchymosis can be seen in the skin, mucous membranes or in the conjunctiva. By means of the ophthalmoscope a diagnosis can possibly be made by the appearance of the eyeground, which reveals hemorrhages, fat droplets in the vessels and a choked disk.

Diagnosis.—Fat embolism is most apt to be confused with shock, especially in the early stages. The following are the more important differential points in the diagnosis between the two conditions:

Shock:
- Happens immediately after the accident.
- Temperature subnormal.
- Respiration shallow.
- Patient pallid.

Fat embolism:
- First symptoms do not appear for at least a few hours.
- The temperature is normal or slightly subnormal.
- The breathing is stertorous.
- The patient is cyanosed.

Between the cerebral symptoms of fat embolism and those of ordinary embolism there is often much difficulty in differentiation. The following are the main points of value:

Fat embolism:
- Pulmonary complications present.
- Pulse rapid and weak.
- Hemiplegia, monoplegia and convulsions rare.

Embolism, apoplexy and traumatic hemorrhage:
- Most probably absent.
- Pulse full, slow bounding, indication of increased cranial tension.
- Focal symptoms (hemiplegia, etc.) present.

In both conditions there may be unconsciousness, coma, localized paralysis and convulsions preceded by an interval of consciousness.

Acute pulmonary affections of other origins need be differentiated from fat embolism. The prolonged administration of anesthetics may give rise to a chain of symptoms not unlike those of fat embolism. The history of the case, such as injury, the use of the ophthalmoscope, acute suppression of the urine, with the appearance of fat droplets in the urine, may be of benefit in arriving at a diagnosis.

Prognosis.—Cases of fat embolism, with severe symptoms, are most often fatal; milder cases are generally recovered from. In severe cases the condition may prove fatal in from three hours to seven days after the injury and in from 24 to 48 hours after the appearance of the symptoms; in mild cases the symptoms last but a few hours. A patient may have two or three attacks, while if the emboli come from an infected source the gravity of the condition is increased.

Treatment.—There is no specific remedy, and so symptomatic treatment must be relied upon. Absolute rest of the injured part should be insisted upon to prevent additional fat globules from entering the circulation. Stimulants should be administered to aid the heart, such as strychnine, alcohol, ammonium carbonate and digitalis. External heat may be employed; diuretics administered hypodermatically. Artificial respiration may tide a patient over a crisis. Oxygen may be of service both to aerate the blood and to oxidize the fat.

FRACTURES OF THE SKULL.

By E. Kilbourne Tullidge.

The skull is the mechanical protectorate of the brain and its anexia, and is divided by most anatomists into two parts: the cranium, derived from the Greek Χράνος, meaning helmet, and the face. The former consists of eight bones, namely, occipital, two temporal, two parietal, frontal, ethmoid and sphenoid, and is the division generally referred to when speaking of fractures of the skull. The latter is composed of fourteen bones and is rarely categoricalized under the general heading of fractures of the skull, the name of the bone injured being usually referred to as facture of the maxilla, of the nose, zygomatic process, etc. We will then only consider here those bones which help to comprise the helmet or true cranium, and in order to systematically speak of these we may conveniently divide them into three classes or groups—placing in the first group fractures of the vault, in the second fractures of the base, and in the

third those fractures complicating both base and vault.

The vault is the most frequent seat of injury being caused by trauma, the bone giving away at the point of contact, causing a simple cracking or fissure. These frequently extend to and involve the base of the skull and are accompanied by considerable hemmorrhage. In such fractures the causative agent acts broadly upon the skull, causing the bones to over exceed their limits of elasticity, consequently modifying their shape and bruising their contents. Should the fissure remain localized in the vault and not complicate the base, it will usually be found to affect only the outer table, and when involving both the outer and inner tables extensive splitting of the latter may occur. A red line on the bone, which persists after sponging, is diagnostic of cranial fracture in practically every case.

In cases of trauma, where the force is consumed in breaking the bone at the point of impact, there is no general change in the shape of the skull. Under this localized impact the bone may give away, both its outer and inner tables being usually driven inward to cause a comminuted fracture. Several cases have been reported where the bones were driven outward. One of these cases I was fortunate enough to examine at the British Museum in London. The skull had been pierced by a rather large bullet fired through the roof of the mouth, and after ploughing through the cerebrum made its exit through the internal and external plates or tables of the frontal bone near the anterior fontanelle, fissuring the bone in several directions. Many of the splinters and pieces remained adherent and protruded outward.

The outer table may be injured without involvement of the inner, or the inner table alone may be depressed or broken, even extensively splintered without any involvement of its outer covering.

The most common form of fracture with depression is that in which several fragments, more or less of a triangular shape, have their points extensively driven downward and finally wedged into each other, while their bases still remain on a level with the surrounding bone; cracks or fissures involving the outer table frequently radiate from the depressed pieces. Fracture alone of the outer plate occurs so rarely that thorough examination, no matter what the condition, will usually show that although the outer plate or external surface alone appears fragmented, the inner plate will prove the involvement to be of a more extensive nature and of a greater degree, probably due to its brittleness, or, as Dr. Agnew has theorized "the greater curvature which it presents." These fractures are almost always compound because of the character of the causative agent, the skin yielding under it like the bone, thus placing it in the class known as compound comminuted, depressed fracture. In the treatment of such cases it is important to recognize the occurrence of fissures, the edges of the torn periosteum or a cranial suture being easily mistaken for them. The importance of recognition is due to the possibility of a more extensive lesion beneath and of infection.

When the bone is broken or depressed fragments must be raised and all the deep particles removed under antiseptic precautions. The wound should then be closed, after hemmorrhage has been controlled, a small opening being left for drainage purposes.

Circumscribed fractures of the skull, although not commonly met with, should be mentioned. The head may present a complete circular solution in the continuity of its bones. The bones may be divided into two lateral halves, which are freely movable. The ethmoid may be driven in by a blow on the nose, and many other such rare conditions may occur.

Fractures involving the base of the skull may also be fissured in nature, being continuations from vault fractures. The frequency of their occurrence may be usually shown in Aran's Law, "fractures of the vault pass to the base by the shortest route." Indirect fractures or fractures by contre coupe occur with a reasonable amount of frequency. The most common of these results from shock transmitted along the spinal column. The condyles of the lower jaw may also be driven through the roof of their socket.

Involvement of the anterior fossa may be caused by wounds through the nose or roof of the orbit, or radiate from fractures of the vault. Blood and spinal fluid may flow freely from the nose, the eyes may bulge and present a subconjunctival echymosis.

The middle fossa is the most frequently involved, the solution occurring through the petrous portion of the temporal bone, opening up

the middle ear and tympanic membrane. The seventh or facial nerve may be involved, and by continuation the fracture may spread to the middle meningeal artery and to the anterior fossa.

The posterior fossa when fractured results more fatally than either of the two just mentioned on account of its proximity to the medulla. The circular fracture or ring fracture occurring about the foramen magnum is a good sample. It may be caused by the impact of the skull through the occipital condyles upon the spinal column. Battle's sign, discoloration of the mastoid region, when obtained is indicative of fracture of the posterior fossa and is usually complicated by brain injury.

There is no specific treatment especially applied to fractures of the base. The area involved should of course be rendered aseptic if possible, the upper part of the nasal fossa being in the majority of instances always sterile. It is quite unnecessary to irrigate the nasal system, as the septic chances far exceed the aseptic ones, and as good results, even better ones, may be obtained by plugging it up with plain or iodoform gauze. The auditory meatus should be treated in a like manner when involved, and the patient placed at absolute rest and quiet in a dark room and special attention given to his assimilation and elimination process.

SIMPLE GANGLION AT THE WRIST.

By Edward H. Schott.

A simple ganglion is a cystic tumor of variable size occurring on a tendon and containing a straw-colored material.

Etiology.—Formerly it was thought to be a herniation of the synovial lining of joints or tendons. This theory, however, has been disputed by Ledderhouse, Thorn and Frenz, who have done a great deal of research work in this subject. They have come to the conclusion that a ganglion is a product of connective tissue degeneration. The connective tissue adjoining the joints or tendons becomes more cellular than usual, the proliferating tissue undergoing collagenous degeneration in foci here and there and forming small minute cysts, which later increase in size, fuse and form one large cyst. Ganglions are most common in adolescents, which is probably due to the many falls and bumps to which youth is heir. It sometimes disappears spontaneously.

Symptoms.—Pain, if present, is slight, but is generally absent. A feeling of weakness is experienced in the wrist upon grasping heavy objects. On inspection we see a tumor attached to the subjacent structures. The tumor is usually immovable except sideways, but the skin moves freely over it. Upon palpation a fluctuation may be detected.

Treatment.—The simplest form of treatment is to place the wrist against something firm and then apply sudden force as by hitting with a book or some other hard object, which will cause the cyst to break and the fluid will be absorbed by the surrounding structures. It is well to apply a tight bandage or pad to the wrist to keep it from filling up again. Another method is to puncture the cyst with a tenotome and let the fluid come out at the side of the knife. The best method is to excise the cyst under aseptic conditions and dress it with sterile gauze and bandage. These cysts have a great tendency to recur, so persons having had them should be very careful not to injure their wrists.

The following is the list of resident medical students at University Hospital for the ensuing year:

C. W. Armstrong, C. C. Ayres, A. Balart, J. W. Blake, C. R. S. Bogart, T. R. Bradley, W. D. R. Brandon, H. W. Byers, J. C. Caldwell, H. E. Clark, A. S. Coleman, LeC. Cook, G. B. Crist, T. McC. Davis, W. L. Denny, Jr., B. H. Guistwhite, C. S. Hassell, C. B. Hicks, E. L. Horger, C. C. Henderson, C. C. Hoke, R. L. Johnson, J. W. Katzenberger, L. M. Limbaugh, C. G. Love, J. F. Lutz, C. L. Magruder, C. H. Metcalfe, J. F. Munnerlyn, R. B. Norment, W. L. Richards, M. D. Smith, W. M. Stahl, H. Stein, G. L. Timanus, P. P. Vinson, F. M. Wilson, F. W. Wilson, J. F. Fenby, C. C. Habliston, J. R. Wanner, D. T. Williams.

Chief Judge Henry D. Harlan of the Supreme Bench has been elected dean of the Consolidated Law School of the University of Maryland and the Baltimore Law School. For some years he has been dean of the law department of the University of Maryland. The combined schools will be known as the Law School of the University of Maryland.

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NATHAN WINSLOW, M.D. J. M. H. ROWLAND, M.D.

BALTIMORE AUGUST 15, 1913.

THE MEDICAL CLASS OF 1881.

It gives us pleasure to add to the list of the members of the class of 1881 who have become professors in the University, the name of Dr. Charles O'Donovan, Jr.

Charles O'Donovan, Jr., graduated in 1881 and has practiced medicine in this city continuously since that time. He is the son of the late Dr. Charles O'Donovan and the grandson of the late Dr. John H. O'Donovan, both of whom were graduates of this school. Dr. Charles O'Donovan, Jr., received his A.B. from Georgetown University in 1878, and A.M. from the same institution in 1888. He was professor of diseases of children, Woman's Medical College of Baltimore, from 1894-99; and held a similar chair in the Baltimore Medical College from 1899 to 1913. Upon the merger of the Baltimore Medical College he became professor of clinical pediatrics and clinical medicine in the University of Maryland. He has been president of the Medical and Chirurgical Faculty of Maryland, and is a member of the Visiting staff of St. Joheph's Hospital. He is a prominent physician and enjoys a large practice. Loyola College conferred the honorary degree of LL.D. on him in 1912.

THE MEDICAL CLASS OF 1882.

We have written short sketches of the classes of 1873 and 1881 because of the close association of several members of each of these classes with the Faculty of Physic, and we now desire to call attention to the class of 1882 for the same reason. This class has been especially identified with the history of the University of Maryland, since three members of it are at this time connected with the institution as professors and another as an instructor.

Hiram Woods, Jr., was born in Baltimore in 1857 and has had a distinguished career. He graduated at Princeton College in 1879, in the same class with President Woodrow Wilson and Prof. Charles W. Mitchell, receiving the A.B. degree. Later he was admitted to the M.A. degree. Having chosen medicine as his life work, he entered the University of Maryland and received his M.D. in 1882. He soon began to specialize in eye and ear diseases and became associated with Prof. Julian J. Chisolm at the Presbyterian Eye, Ear and Throat Hospital. His rise in his specialty and in the profession was rapid. From 1888-1895 he was professor of eye and ear diseases in the Woman's Medical College of Baltimore; and upon the retirement of Professor Chisolm in 1895 he was made clinical professor, and in 1902 professor of eye and ear diseases in the University, in which positions he has been a great ornament to the school. He is deservedly popular with the students, as he is not only a lucid teacher, but a sympathetic friend of the young men with whom he is brought in contact. In addition to his large private and public practice and to the duties of his chair, he has held many offices of trust and honor, such as president of the Medical and Chirurgical Faculty of Maryland, and chairman of the section on ophthalmology of the A. M. A.

John Mason Hundley was born in Virginia in 1858 and received his primary education largely from his father, who was a clergyman of the Protestant Episcopal Church. He entered the Maryland College of Pharmacy in 1876 and graduated in 1878. He then followed the avocation of a druggist for several years, but determining upon a medical career, he entered the University as a medical student and graduated with first honors in 1882, having been the recipient of the University gold medal. He then settled in Baltimore as a general practitioner and succeeded in securing a large practice. His attention, however, began to be more and more directed toward gynecology as a specialty, and he soon became associated with Prof. William T. Howard as an

assistant and served under him for many years. He has filled the several positions of chief of clinic, associate professor of gynecology, clinical professor and, finally, professor of clinical gynecology. He is now an abdominal surgeon of wide repute and excellent skill—careful, painstaking and conscientious. He is also a valued teacher, laying especial emphasis on careful technique and accurate diagnosis.

James M. Craighill was born at Georgetown, D. C., in 1857. He is the son of the late General Craighill, chief of engineers of the United States Army. His academic education was obtained at the Episcopal High School, Alexandria, Va. He entered the University of Maryland in 1879 and graduated M.D. in 1882. During his student days he was epecially interested in anatomy and subsequently became an assistant demonstrator of anatomy. After graduation he was a resident physician at Bayview Hospital and later an acting assistant surgeon United States Army, seeing much hard service in the Northwest in 1882-83. Returning to Baltimore, he settled in general medical practice and has been an useful and honorable member of the profession. He has served as chief of the medical clinic, associate and clinical professor of medicine, and now has the rank and title of professor of clinical medicine. He is a progressive physician, a faithful officer and an absolutely loyal alumnus.

Henry Chandlee, the fourth member of the class of 1882 to be connected with the University, came to Baltimore from Kent county, Maryland. He has been a practitioner of medicine in this city for 30 years, but has been especially interested in X-ray work for many years. In fact, he was the first to take up the X-ray in this city and has become very expert in this line of work, as well as in general photography. He is now instructor in radiography and is the radiologist to the University Hospital, and by his invariable courtesy, his painstaking devotion to his duties and the excellence of his work he has become an invaluable member of the hospital staff.

THE PATHOLOGICAL ENDOWMENT FUND.

No effort has been made during the past month to increase this fund. Professor Winslow has been away and the weather has been too hot for effort of this character.

CONTRIBUTIONS BY CLASSES.

1848	$50 00
1864	20 00
1868	10 00
1871	35 00
1872	86 84
1873	491 83
1874	5 00
1875	5 00
1876	115 00
1877	10 00
1880	5 00
1881	255 00
1882	310 00
1883	40 00
1884	40 00
1885	235 00
1886	100 00
1888	50 00
1889	100 00
1890	200 00
1892	150 00
1893	40 00
1894	135 00
1895	155 00
1896	52 00
1897	80 00
1898	115 00
1899	55 00
1900	220 00
1901	270 00
1902	330 00
1903	375 00
1904	135 00
1905	220 00
1906	230 00
1907	120 00
1908	50 00
1909	40 00
1910	75 00
1911 Terra Mariae	3 50
1912 Club Latino Americano	25 00
1913 Club Latino Americano	30 00
Total subscriptions to Aug. 1, 1913	$10,630.17

NEW SUBSCRIPTIONS IN JULY, 1913.

Dr. Robert T. Wilson, 1881	$3 00
Dr. N. W. Hershner, 1906	25 00
Total	$28 00

WEALTH ALONE IS NOT AN UNALLOYED BLESSING.

The country has gone money mad and only sees good in those of large fortunes. This applies equally as forcibly to institutions as individuals. If a university is poor, the edict is it has no right to existence, though it may be doing a most meritorious work among the youth. Because a silly fad is taken up by a rich individual, corporation or institution does not make it right. Money never could and never will make right out of wrong. With money comes its evils. In institutions we see it manifested by a false standard of exclusiveness, the so-called fashionable schools, where democracy gives way to aristocracy and the poor boy is not welcome. It is hard to believe that our philanthropists founded institutions to create and foster a class spirit, for ability is not limited to any one strata of society, but is found in the farmer's boy as often as in the millionaire's son. Moreover, an impractical head of a wealthy institution may, and often does, institute the most nonsensical fads, which serve in the minds of some as the acme of scholastic development.

The poor institution, not having sufficient funds to take up the foibles of the day, is compelled to give an every-day, common-sense course, to which the rich and poor boy alike are welcome. It is the leavening ground of our complex society, and for this reason justifies its existence. An institution to justify its existence must give the nation men capable of doing something worth while.

A. G. Crandall, writing along this line in the *Monthly Cyclopedia and Medical Bulletin,* says:

"It is reported by the graduating class of a well-known Eastern university that the average expenses for the four-year course were $4200.

"A large number of benevolently disposed people have from time to time contributed to establish various endowment funds for different schools and colleges, believing that their generosity was likely to result in permanent benefits to struggling students for a long time to come.

"It is a significant fact that a struggling preparatory school with little or no endowment will often extend a much more cordial welcome to poor students than will be the case after the school has acquired sufficient endowment to place it in a position of comparative independence. The unfailing impulse under such circumstances seems to be to attempt to secure the patronage of a wealthy class of students, to raise the rates in order to provide an atmosphere of exclusiveness and to exhibit a diminishing degree of cordiality toward the class of students on whose patronage they depended at an earlier period. As proof of this statement it is only necessary to refer to the fact that the students' expenses at some of the most richly endowed preparatory schools and universities are 50 if not 100 per cent. higher than they are at some of the smaller institutions. Of course, the excuse is that the endowed institutions can provide greater advantages, but the fact remains that the graduates of the smaller colleges undoubtedly average fully as high in natural ability and in future usefulness as do the graduates of the institutions upon which gifts have been lavishly bestowed by people who felt that in doing so they were conferring privileges upon generations of students yet unborn.

"It is likely that there will be an increasing degree of curiosity manifested before long as to why the students' expenses at various private educational institutions should steadily increase in proportion as the endowment fund increases."

ITEMS

Dr. Wilfred R. Claytor, class of 1912, formerly an assistant resident surgeon of St. Joseph's Hospital, this city, is ill of typhoid fever at his home in Georgia.

Dr. W. Clement Claude, '75, of Annapolis, Md., Major, First Infantry, Maryland National Guard, who has been encamped with the regiment at Belair, has returned to his home in Annapolis. Major Claude is the ranking major in the First Brigade, Maryland National Guard.

Dr. Thomas Fell, provost of the University of Maryland, is spending the summer with his family at Skyland, Va. On July 17 a dinner was given in his honor. Ferns and yellow mountain lilies were the table decorations. A program of appropriate selections was rendered by a string orchestra. At the conclusion of the dinner a huge birthday cake was cut by Dr. Fell and distributed to the guests. Dr. Fell will return to his home in Annapolis in the early fall.

Dr. Louis McLane Tiffany, class of 1898, who has been visiting relatives in Boston, has gone to Magnolia, where he will spend the remainder of the summer.

Dr. John Turner, class of 1892, who has been visiting friends at Cockeysville, has returned home.

Dr. C. Urban Smith, class of 1880, of 817 Park avenue, is spending some time at Eaglesmere, Pennsylvania.

Dr. H. D. McCarty, class of 1905, of 37 W. Preston street, left recently for Beach Bluff, Massachusetts.

Dr. Ivey Pearlstine, class of 1906, of 30 George street, Charleston, S. C., has been elected clinical assistant in general surgery to the new Medical College of the State of South Carolina. He has also been one of the visiting surgeons to the Roper Hospital for the past two months, during which time he has had several interesting cases, among which was that of a colored man operated on for stab wound of the heart. The patient survived 28 hours. After exposing the heart, Dr. Pearlstine found it necessary to take five stitches. It is rare that a man has an opportunity to perform such an operation, and we wish that the outcome had been different.

We are glad to announce that Dr. H. M. Robinson, class of 1909, 2010 Wilkens avenue, Baltimore, has sufficiently recovered from an acute attack of nephritis, superinduced by an anesthesia for the removal of his tonsils, to resume his practice.

Dr. John C. Hemmeter, class of 1884, of 1734 Linden avenue, who is spending the summer at Hot Springs, Va., recently entertained the physicians at dinner. Covers were laid for 12. Dr. Hemmeter will return to his home in the fall.

Dr. Bennett F. Bussey, class of 1884, of Texas, Md., has announced himself as a candidate for the office of Register of Wills, subject to the Democratic primary. Dr. Bussey has many friends in the medical profession, and is a former president of the Baltimore County Medical Association.

During the recent encampment of the Maryland National Guard at Belair, Md., a field hospital was established with Captain Howard E. Ashbury, class of 1903, of 1017 Cathedral street, in charge.

Dr. Charles L. Mattfeldt, class of 1880, of Catonsville, Md., is a candidate for County Commissioner, to succeed himself.

Dr. Frank Martin, class of 1886, 1000 Cathedral street, will spend the month of August motoring through the New England States.

Dr. Charles Teackle Buckner, class of 1899, of North Charles street, will leave in August for North Hatley, Canada, where he usually spends part of each season.

Dr. Walton H. Hopkins, class of 1904, of Annapolis, Md., who has been spending some time at Atlantic City, has returned home.

Dr. John R. Irwin, '77, of Charlotte, N. C., has been elected orator of the North Carolina Medical Society, and Drs. J. L. Spruill, '95, of Columbia; Peter John, '97, of Laurinburg; R. L. Felts, '98, of Durham, and A. J. Crowell, '93 of Charlotte, councilors.

Dr. Joshua W. Hering, '85, of the Public Service Commission, who has been ill at his home in Westminster, is very much improved and attended the meeting of the Commission on the 17th. His many friends are glad to see him out again.

Major P. L. Boyer, '99, Medical Corps, U. S. A., of Chicago, Ill., was in charge of the hospital attached to the Southern camp at the Gettysburg Reunion. There were about 800 Southern veterans treated in it.

We are glad to learn that Dr. Guy Steele, '97, of Cambridge, Md., who has been a patient in

the University Hospital with a dislocated wrist, is able to be out again. It occurred while cranking an automobile about five weeks ago.

The engagement of Dr. Isaac M. Macks, '11, to Miss Rose Finder, both of this city, is announced. The wedding will take place shortly.

Dr. Alexander D. McConachie, '90, of 805 N. Charles street, will spend August motoring through Northern resorts and Canada.

Dr. L. Ernest Neale, '81, of 108 E. Read street, professor of obstetrics, is spending the summer at Ocean City, Md.

Dr. Ridgely B. Warfield, '84, of 845 Park avenue, sailed July 12 from New York on board the steamship George Washington for Europe, where he will make a tour of the British Isles, Iceland, Norway and Sweden, returning to this country in September.

Major Roger Brooke, Medical Corps, U. S. A., Baltimore Medical College, 1900, is stationed at the Presido, San Francisco. He has spent much of his time since graduation in the Philippines. He paid a recent visit East, and while in Baltimore visited the college and hospital.

Drs. A. J. Crowell, '93, and C. M. Strong, '88, of Charlotte, N. C., sailed for Europe July 3.

Dr. John S. McKee, '07, has been elected City Physician of Raleigh.

Another recent visitor to the college was Dr. A. G. Shortle, Baltimore Medical College, '96, who is located at Albuquerque, N. Mex., where he has a sanatorium for the treatment of tuberculosis. He is president of the State Tuberculosis Association of New Mexico.

Dr. Ernest Rowland, Baltimore Medical College, '95, is president of the Cecil County Medical Society.

Drs. Eugene Hagan Mullan, '03, and Lawrence Kolb, '08, Assistant Surgeons United States Public Health Service, are now on duty at the Ellis Island Immigration Station. Dr. Mullan will shortly take his examination for Passed Assistant Surgeon.

Dr. Thomas C. Gilchrist, professor of dermatology, sailed for England July 22, where he will spend the remainder of the summer.

Dr. Richard H. Lewis, '71, of Raleigh, N. C., former secretary of the North Carolina State Board of Health, was presented with a gold-headed cane by the North Carolina State Health Officers' Association, June 16, in recognition of his splendid work for the State in public health.

Dr. Henry R. Carter, '79, United States Public Health Service, Surgeon-in-Charge at Baltimore, recently gave a number of lectures on the Panama Canal to the students of the University of Minnesota at Minneapolis. His topics were sanitation, engineering and domestic arrangements, on which his six years' experience as assistant chief sanitary engineer qualified him to speak authoritatively.

Dr. Charles H. A. Meyer, Baltimore Medical College, '88, sailed for Europe June 24. After spending the summer abroad, Dr. Meyer will return to this country in the fall.

Dr. James A. Nydegger, '92, United States Public Health Service, stationed at Baltimore, has been elected professor of tropical medicine in the University, and will lecture there next session.

Dr. John R. Irwin, '77, of Charlotte, N. C., has been elected vice-president of the North Carolina Medical Society.

Dr. Harry Adler, '95, of 1804 Madison avenue, sailed for Europe June 24, where he will spend the remainder of the summer, returning to this country in the fall.

Among the recent visitors to the University Hospital were Drs. Charles Wesley Roberts,

class of 1910, of Douglas, Ga.; Lay Gordon Burroughs, class of 1906, of Collinsville, Ill., and Edward R. Hart, class of 1901, of Suffolk, Va.

Dr. Willis Linn, class of 1911, is located at 624 Franklin street, Wilmington, Del.

Dr. Ebenezer W. Pressly, '87, of Clover, S. C., has been appointed a member of the South Carolina State Medical Examining Board.

Dr. William B. Burch, '90, of Baltimore, was the orator at the commencement of Leonard Hall School, Leonardtown, Md., June 19.

Dr. Bernard Levinson, Baltimore Medical College, '08, is located at 612 W. Front street, Plainfield, N. J., where he is practicing his profession.

Dr. William L. Burns, class of 1908, of 183 Baltimore street, Cumberland, Md., has sailed for Europe, where he will remain until the fall, when he will return to his home.

It may be of interest to our alumni to learn that William H. Maxwell, City Superintendent of Schools, announces that an examination of applicants for license as Assistant Director of Educational Hygiene in the schools of the City of New York will be conducted by the Board of Examiners on Monday, September 29, 1913, at 9 A. M., at the Hall of the Board of Education, Park avenue and 59th street, Manhattan. An oral examination of such applicants will be held later at the call of the Board of Examiners.

Requirements for Eligibility—Applicants must present evidence of good moral character, and must have the qualifications described under (a) and (b) following. No applicant will be admitted to this examination who will not have accomplished the required experience before September 29, 1913.

(a) Graduation from a medical school recognized by the Regents of the University of the State of New York.

(b) One year of specialized experience in pediatrics.

Scope of Examination—Written examination—The practice of medicine in all of its branches, with particular reference to disease or disability which may occur during school life. Emphasis will be placed upon pediatrics and upon the hygiene of the teacher. The examination will include such topics as school hygiene and sanitation, the processes of growth and development, with particular reference to school life, tests of mental and physical health and efficiency.

An oral examination will be held at the call of the Board of Examiners. This will consist of an oral quiz, an examination on physical diagnosis and clinical tests which will be held at a clinic to be designated by the Board of Examiners, and, in addition, candidates will be taken to a public school for a conference quiz on school hygiene, school sanitation and hygiene of the pupil and teacher.

The applicant should file at the time of the examination all evidence of eligibility, properly certified, and should file all pamphlets and publications which contain original matter written by the candidate on topics which come within the scope of the examination.

Physician's Certificate—Applicants for license as Assistant Director of Educational Hygiene must present evidence of sound physical health in the form of a certificate to be issued by one of the physicians of the Board of Education.

Tenure of License and Duration of Eligible List—The license issued under these regulations hold for one year from date of appointment, and may be renewed for two successive years, without examination, in case the work of the holder is satisfactory. At the close of the third year of continuous successful service the City Superintendent may make the license permanent. Under section 1089 of the City Charter, as amended in 1912, an eligible list of licensees as assistant director of educational hygiene continues in force for three years.

Salary—The present salary schedule of assistant directors of educational hygiene is as follows: First year, $2500; an annual increase of $100 until the maximum of $3000 is reached, which shall be the salary for the sixth and for succeeding years.

The examination will begin promptly at the time stated, and no applicant who is late will be admitted to the examination.

Dr. Hiram Woods, class of 1893, of 842 Park avenue, delivered the principal address on "Pre-

ventable Blindness" at the joint society meeting of the Washington County Medical Society and the Frederick County Medical Society, July 24, 1913.

Dr. E. H. Rowe, class of 1906, of the Homewood Apartments, who has been spending some time abroad, has returned home and resumed his practice.

Dr. E. L. Whitney has been appointed associate professor of physiological chemistry, pharmacy and clinical pathology, and Dr. H. R. Spencer associate professor of pathology and bacteriology in the University of Maryland.

The following alumni, Baltimore Medical College, are located in Virginia:

Stanley E. Young, class of 1893.
W. W. Cummings, class of 1905.
Benjamin L. Carter, class of 1893.
William C. Webb, class of 1904.
Henry W. Anderson, class of 1883.
Charles P. Rexrode, class of 1896.
William E. Brown, class of 1908.
Joseph Henry Mitchell, class of 1895.
L. D. Caldwell, class of 1893.
Simon P. Conduff, class of 1898.
James Alexander Grizzard, class of 1906.
Fred C. Downey, class of 1898.
J. M. Sheppard, class of 1894.
Archibald McDowell Burfoot, class of 1906.
Joseph G. Bishop, class of 1905.
C. M. Easter, class of 1895.
Claude David Combs, class of 1909.
Paul Jones Parker, class of 1910.
Chester B. Nuckolls, class of 1893.
L. J. Marshall, class of 1900.
Edgar A. Pole, class of 1897.
Ossie Alexander Weatherly, class of 1909.
M. W. Jewett, class of 1882.
Emory Gordon Valk, class of 1897.
Charles Stickley, class of 1904.
Jesse M. Shackelford, class of 1891.
Carl C. White, class of 1897.
Davis L. Shaver, class of 1888.
Edgar W. Young, class of 1911.
Noah F. Schumucker, class of 1897.
Luther M. Abbott, class of 1898.
Calvin W. Cahan, class of 1891.
Thomas J. Wolf, class of 1890.
George Albert Arhart, class of 1910.
James Turner Kelly, class of 1893.
Thomas E. Patterson, class of 1909.
Wade H. Whitehead, class of 1907.
William Forrest Becker, class of 1911.
Clarence C. Jones, class of 1903.
William H. Thomas, class of 1889.
Isaac Webb Surratt, class of 1908.
William Otey McCabe, class of 1892.
James White Johnson, class of 1907.
Jos. Edward Brumback, class of 1909.
Jos. Cleveland Rutrough, class of 1910.
William Pendleton McQuire, class of 1903.
W. B. Richardson, class of 1895.

MARRIAGES

Dr. Paul Brown, class of 1909, formerly of Gaffney, S. C., to Miss Viola Edmondson of Baltimore, Md., at Baltimore, June 25, 1913. They left immediately for a Southern trip, and upon their return will live at 1841 Pennsylvania avenue, Baltimore, where the groom is practicing his profession.

Dr. James Emery, class of 1904, of Daytona, Fla., to Miss Madge Mogee, of Morristown, Pa., at Morristown, May 22, 1913.

Miss Eliza Nalley Ridgely, University Training School for Nurses, class of 1912, of Baltimore, to Mr. John Charles Ringgold, at Baltimore, July 14, 1913. After a short wedding trip Mr. and Mrs. Ringgold will reside in Chicago, Ill., where Mr. Ringgold is in business.

Miss Cora Nellie Burton, University Training School for Nurses, class of 1910, of Hamilton, Md., to Mr. Richard Tilghman Earle of Centerville, Md., at Hamilton, July 19, 1913. Mr. and Mrs. Earle will reside at Centerville, and will be at home to their friends after August 1.

Dr. George A. Anderton, Baltimore Medical College, '07, of Morris Plains, N. J., to Miss Minnie P. Newman of Catonsville, Md., at Catonsville, June 25, 1913. After a wedding trip spent in Canada, Dr. and Mrs. Anderton will reside at Greystone Park, N. J., where Dr. Anderton is connected with the New Jersey State Hospital.

DEATHS

Dr. Pride Jones Thomas, class of 1902, of Wilmington, N. C., a member of the Medical Society of the State of North Carolina, and assistant surgeon of the Atlantic Coast Line at Wilmington, died at his home in Wilmington of valvular heart disease, June 24, 1913, aged 38 years.

Dr. Isadore Clarence Smulyan, Baltimore Medical College, class of 1901, of Salt Lake City, Utah, a member of the State Board of Medical Examiners, died in the Holy Cross Hospital, Salt Lake City, from nephritis, June 30, 1913, aged 35 years.

Dr. Wm. Frederick A. Kemp, class of 1872, of Baltimore, formerly vice-president and for many years treasurer of the Medical and Chirurgical Faculty of Maryland; president of the Baltimore Medical Association, and one of the best-liked physicians in the city, died at his home, 8 W. 21st street, of a complication of diseases, July 10, 1913, aged 64 years.

Dr. Joseph C. Wunder, class of 1889, of 1800 W. Baltimore street, the well-known West Baltimore physician, died from tuberculosis at the State Sanatorium at Sabillasville, July 20, 1913, aged 48 years.

Dr. Joseph Morton Bunting, Baltimore Medical College, class of 1909, a member of the Medical Society of the State of New York, died recently at his home in Kingston, aged 28 years.

Dr. James Henry Murray, a graduate of the Maryland Medical College, and at one time a member of the class of 1912, University of Maryland, of West River, Md., died at St. Luke's Hospital, July 24, 1913, aged 24 years, of intestinal obstruction. After graduation Dr. Murray served as an interne in the Bayview Hospital, and on June 1 last entered St. Luke's as an interne. Only three weeks previous to his last illness, Dr. Murray had recovered from an attack of diphtheria. His many friends, especially those who were connected with him as house students, will regret to learn of his sudden death.

Dr. Edward L. Downs, class of 1880, died at Butler, Pa., March 27, 1913, aged 55 years.

Dr. James P. Carter, class of 1852, died at his home in Gerrardstown, W. Va., August 2, 1913, aged 87 years.

Dr. Monte Griffith, class of 1890, of Washington, D. C., a member of the American Medical Association and Washington Ophthalmological and Otological Society, assistant professor of ophthalmology in Georgetown University, assistant surgeon to the Eye, Ear and Throat Hospital and ophthalmologist to the Children's Hospital, Washington, and for many years a practitioner of Washington, died at his home in Cherrydale, Va., where he had lived since his retirement, two years ago, of angina pectoris, July 11, 1913, aged 51 years.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., of THE HOSPITAL BULLETIN OF THE UNIVERSITY OF MARYLAND, published monthly at Baltimore, Md., required by the Act of August 24, 1912.

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Business Manager, Nathan Winslow, M.D., 3304 Walbrook avenue, Baltimore, Md.

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C. W. Mitchell, 1002 Cathedral street, Baltimore, Md.
R. L. Mitchell, 2112 Maryland avenue, Baltimore, Md.
O. P. Penning, 1711 St. Paul street, Baltimore, Md.
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J. D. Reeder, 639 North Fulton avenue, Baltimore, Md.
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Known bondholders, mortgagees, and other security holders, holding 1 per cent. or more of total amount of bonds, mortgages, or other securities, none.

NATHAN WINSLOW, Editor.

Sworn to and subscribed before me this 18th day of April, 1913.

J. ALEX. HILLARY, JR.,
Notary Public.
(My commission expires May 4, 1914.)

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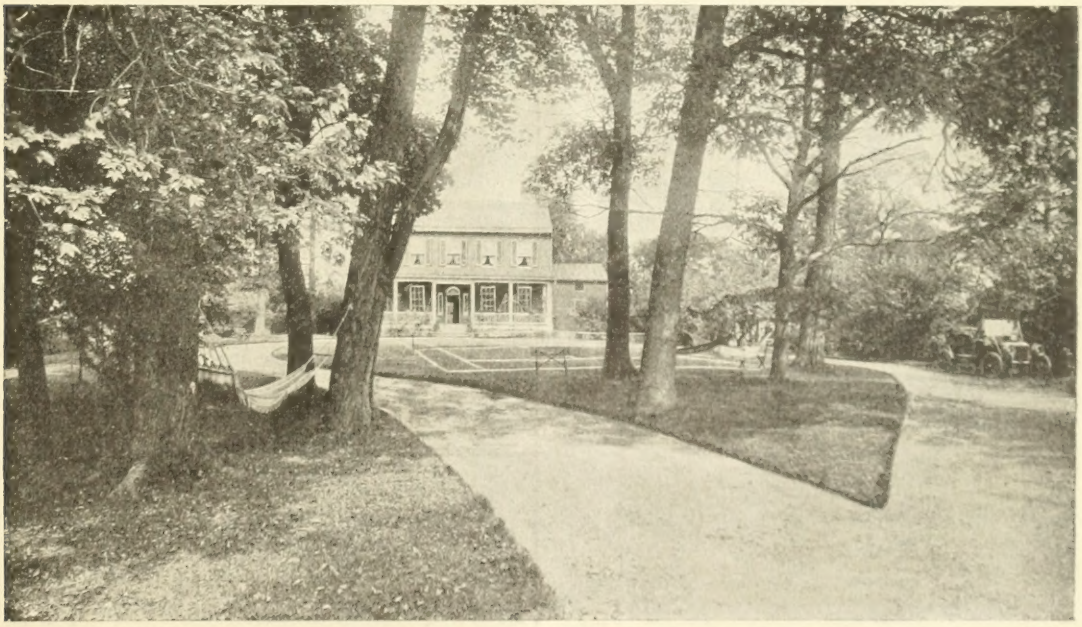

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